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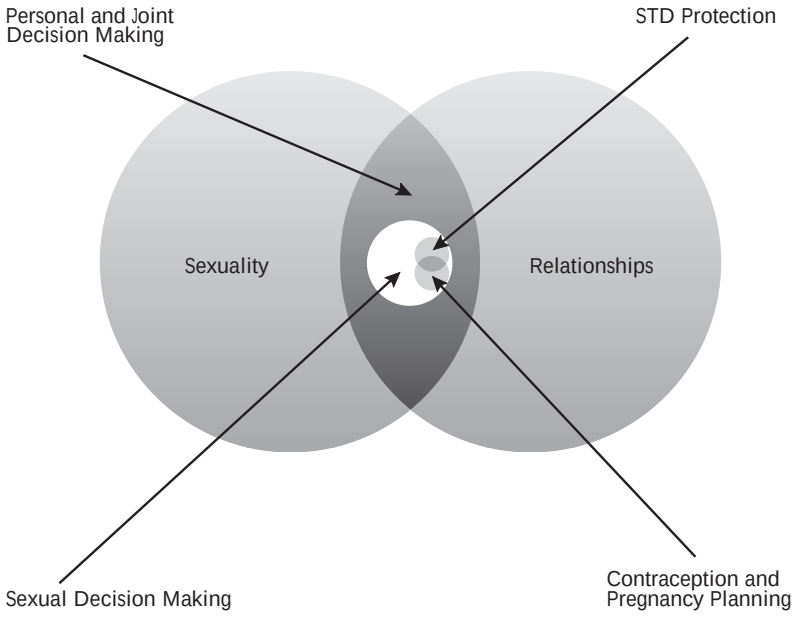
Sexuality and Reproductive Health

Nonke came many times to the family planning clinic. She asked questions about the contraceptive she used. She did not ask why she had pain when her husband entered her during their lovemaking. She was embarrassed to bring up such matters. Yet she desperately wanted to do something so she could give her husband more satisfaction and so she too could experience the pleasure she heard her friends mention.

Contraception is a significant part, but still only a part, of family planning. Family planning, in turn, is a very small part of sexuality (see Figure 10:1). Family planning practitioners have a unique opportunity to supply sexual counseling services to patients who might have no other readily available resource for help.

Figure 10:1 Sexuality, family planning, and safer sex



TAKING A BRIEF SEXUAL HISTORY

If you have time to ask only one question of each patient, a reasonable choice might be:

What do you do to protect yourself from AIDS?

The patient who responds, "Who, me?" can be encouraged to look closely at whether there is any risk for sexually transmitted infection (STI) in her or his present or past sexual relations. The patient who says, "I use condoms every time I have sex" can be praised, reinforced on correct condom use, advised about where to get free or inexpensive condoms, and reminded that condoms sometimes slip off or break.

If you have 2 to 5 minutes, ask these 10 questions to get a basic history:

1. Have you had a sexual experience with another person in the past year?
2. (If yes to question 1) With how many different people? One? Two or three? Four to 10? More than 10?
3. (If yes to question 1) In this past year, have you had sex with men, with women, or with both?
4. Can you tell me about your sexual life before this last year?
5. Have you ever had a sexually transmitted infection of any kind?
6. Have you ever shared needle or injection equipment with another person for any reason?
7. Have you ever felt for any reason that a sex partner put you at risk of infection?
8. What do you do to protect yourself from AIDS?
9. What do you do to protect yourself from unplanned pregnancy?
10. Is there anything else about your sexual lifestyle I need to know to take the best possible care of you?

If you have longer than 5 minutes, add questions about specific sexual practices, gynecological problems related to sexual function, relationships, alcohol and drug use, and sexual dysfunction.

It is appropriate to allow patients to defer the sexual history until a later visit or to decline to discuss sexual issues altogether. Once you have expressed your view that the sexual history is a normal and valuable part of the health history for all people, the patient will decide whether to respond.

THE PLISSIT COUNSELING MODEL

The PLISSIT counseling model was developed for health care workers who are not psychiatrists, psychologists, or sexual therapists but who wish to address the sexual needs and concerns of their patients and make appropriate referrals when necessary.[1] It consists of four stages: Permission giving, Limited Information giving, Specific Suggestions, and Intensive Therapy.

Permission giving is telling the patient that being sexual in his or her own way is acceptable. Permission giving from a knowledgeable professional figure is quite powerful. However, health care workers are not required to give permission for thoughts, feelings or behaviors that violate their own professional value system. Furthermore, professionals ought not approve of behaviors that threaten the physical or psychological health of patients and their partners.

Limited information giving usually involves discussing anatomy and physiology as well as dispelling myths about sex.

Specific suggestions involve skill-building such as changing position for intercourse and other activities, using lubricants, or using a squeeze or stop-start technique.

Intensive therapy will probably prove too time-consuming and involved for all but those who are specially trained and wish to devote considerable time to such work. Intensive therapy may be necessary for body image problems, relationship problems, identity issues, depression, personality disorders, or psychoses.

HUMAN SEXUAL PHYSIOLOGY

Sexual arousal may be caused by a dream, a fantasy, a memory, or any of the five senses: taste, smell, sight, sound, or touch. Couples can enjoy a wide range of intimate sexual expressions—from holding hands, hugging, kissing, massage, and dancing to petting, mutual masturbation, anal stimulation, oral-genital sex, and so on. Sexual practices vary from

individual to individual and from culture to culture. One common factor can be found in all these expressions: *touching*. People need touching for nurture, for solace, for expressing simple affection, for communicating, and for sexual gratification. This chapter does not describe specific sexual practices but discusses the physiology of the sexual response, the contraceptive's effect on that response, and information for counseling couples on sexual dysfunctions. Researchers describe four physiological stages of sexual response as listed in Table 10:1.

One significant difference between men and women has to do with the ease of attaining multiple orgasms during a single sexual episode. Women are physiologically capable of moving between plateau and orgasm one or several times.

Men have a refractory period that follows ejaculation. During the refractory period, they have difficulty achieving a second erection, and after they attain an erection, it may be difficult to have orgasm and ejaculate. The length of the refractory period gradually increases as men grow older. It may be only 5 to 15 minutes in an 18-year-old, but by the age of 60, the refractory period may be 18 to 24 hours. The length of the refractory period varies widely. In general, the more frequently a man ejaculates, the shorter his refractory period.

Female Response and Sensitivity

Virtually any portion of a woman's skin may give pleasurable and exciting sensations when caressed, providing she is willing and not distracted. Women vary greatly in what sort of stimulus produces orgasm. It is common to find healthy, normal women who are orgasmic by some means but are not orgasmic with penile-vaginal thrusting alone. However, regardless of the method by which they are produced, orgasms are physiologically identical, except perhaps in duration.

Table 10:1 Stages of sexual response

Stage	Sexual Response
Excitement	*Males:* Pelvic engorgement, erection. *Females:* Lubrication and dilation of the upper vaginal canal. Both men and women have increased muscle tension, increased heart and respiratory rate, and increased blood pressure. The focus of attention becomes more centered on sexual matters.
Plateau	Sustained engorgement, muscle tension, elevated heart and respiratory rates, and elevated blood pressure for a period that may last from minutes to hours.
Orgasm	Rhythmic contractions of pelvic voluntary and involuntary musculature in both sexes. In men, this action can result in ejaculation of semen. Orgasm is a beginning of relief from tension.
Resolution	Gradual loss of muscle tension, progressive relaxation, and often a sense of drowsiness and contentment. Blood vessels open to drain pelvic and genital engorgement, and gradually (usually over a period of minutes) the individual returns to a nonexcited state.

Source: Masters and Johnson (1966)

Breast and nipple sensitivity tends to be high in most women, but some women do not find breast caressing particularly arousing. For most women whose genitals are intact, the glans and shaft of the clitoris, the inner surfaces of the labia minora, and the first inch and a half of the vagina are the most sexually sensitive areas of all. Indeed, the clitoral head (glans) may be so sensitive that direct touch is sometimes or always uncomfortable. Some women have an area of sexual sensitivity beneath the anterior wall of the vagina about halfway from the hymenal ring to the vaginal vault. (Genital mutilation or circumcision can interfere greatly with these physiological sensations and can

leave a woman with little or no feeling or with painful sensations.) Women may respond sexually to anal stimulation.

Ejaculation of fluid from the urethra at orgasm should be regarded as a normal female sexual response and not as urinary incontinence. Usually, a folded bath towel under the woman's hips is sufficient to keep sheets and bedclothes from becoming dampened. The source and function of this sexual event remain poorly understood.

Male Response and Sensitivity

Men tend to find genital sexual stimulation more intense than whole-body touch arousal. Nipple stimulation may be as arousing for men as it is for women. The genital sites of highly pleasurable sensitivity (in order of decreasing response to touch) are as follows:

- Area of frenular attachment on ventral surface of penis, just behind the glans
- Coronal ridge of glans
- Urethral meatus
- Shaft of the penis
- Penile base, which is located within the perineal area between the area of scrotal attachment and the anus
- Scrotum and testicles (gentle manipulation only)
- Perianal skin

EFFECTS OF CONTRACEPTION AND SAFER SEX ON SEXUAL FUNCTION

The family planning provider should remember that contraception and sexual practices can influence the client's ability to function sexually. Generally, candid communication can help the client avoid or overcome many negative influences.

Fear of Infection

Worry about human immunodeficiency virus (HIV), genital warts, and other incurable viral sexually transmitted infections often affects a couple's sexual experience. The clinician's task is to help patients at risk for these infections to keep sex pleasurable and infection free.

Fear of Pregnancy and Infertility

For men, the subject of pregnancy may cause concern, but their level of concern tends to be lower than that for women. Among women, feelings about pregnancy have an impact that men generally do not feel. For couples trying to conceive, instructions to have intercourse around ovulation can be stressful for both partners. The fear of an unintended pregnancy can decrease an individual's enjoyment.

Lactation

Reassure patients about the naturalness of sexual feelings associated with breasts. In cultures where the breast is considered an erotic object, some new fathers may be confused about their feelings about their partner's breasts while milk flows from them. Some fathers wrongly fear that intercourse will spoil the mother's milk.

Combined Oral Contraceptives

Decreased sex drive is an occasional side effect of oral contraceptives. Patients with this symptom will frequently report it. However, young women who are virgins may not realize that their desire is affected by the pill. Another concern is that couples who use the pill may be reluctant to interrupt lovemaking to add condoms or other methods for STI protection.

Diaphragms and Other Vaginal Barriers

Some women who request diaphragms may initially feel uncomfortable about inserting the device. A poorly fitted diaphragm may cause discomfort and thus inhibit sexual enjoyment. A diaphragm that is too large may press too hard against the tissues; one that is too small may become dislodged when the vagina expands during sexual excitement. The extra lubrication these products supply is pleasant for some couples and a messy interference for others.

Condoms

Some men lose their erection rapidly after ejaculation, and others maintain a relatively erect penis for some time. All men should hold the rim of the condom at the base of the penis as they withdraw to prevent the condom from slipping off. For couples with any STI risk, a condom should be put on *before* the penis comes in contact with the vagina, anus, or mouth, even before ejaculation is pending.

Coitus Interruptus (Withdrawal)

Withdrawal requires the man to do the opposite from his usual desire (*i.e.*, he must pull out and move away from his partner when his desire is to push deeper, clasp, and hold more firmly). This method may leave some women without orgasmic relief. The couple should make a special effort to continue sexual play after withdrawal to make sure both partners have achieved gratification and relief of sexual tension.

Semen remains on the penis after ejaculation. Thus, the man should not put his penis back into the vagina until he cleans his penis and also urinates to flush out the urethra.

Abstinence

Couples may achieve satisfaction with sexual abstinence as long as both select this alternative as the one that most closely meets their

individual needs. However, the couple practicing sexual abstinence may lose a major method of nonverbal communication in their relationship and may find it difficult to compensate by communicating in less intimate ways. They must make special efforts to maintain or strengthen other forms of communication.

FEMALE AND MALE SEXUAL DYSFUNCTIONS

When anything occurs to distract a person from excitement, then erection (in men), lubrication (in women), and orgasm or ejaculation may be impeded. Medications that affect the autonomic nervous system or have a sedative effect may cause a change in sexual function.

LOSS OF DESIRE

Loss of desire may follow previous experiences that have caused embarrassment, pain, or inadequacy. Other important reasons for losing desire include the following:

- Estrogen deficiency with secondary vaginal atrophy (whether postsurgical or postmenopausal) commonly leads to dyspareunia, which is painful penis-in-vagina intercourse. This condition often can be treated successfully with topical or systemic estrogen therapy.
- Birth control pills may diminish desire in some women, but diminished desire in pill users is more often associated with psychological factors (depression, grief, suppressed anger, etc.).
- Chronic fatigue affects both male and female sexual responsiveness. Any time a primary care-giving parent has a young child and complains of diminished responsiveness, then chronic fatigue should be considered as an important contributing factor.
- Debilitating diseases and conditions such as childbirth, surgery, cancer, chronic dieting, and excessive weight loss may

temporarily or permanently diminish desire and responsiveness.

- Medical disease may negatively affect sexual responsiveness. About half of female diabetics will eventually become anorgasmic. Organic pelvic or genital disease may lead to dyspareunia and eventual secondary loss of desire.

Female Sexual Dysfunctions

Anorgasmia

Primary Anorgasmia. Some women are orgasmic during their first sexually exciting experience, and others never learn to have an orgasm. Women who have primary anorgasmia sometimes achieve a relatively low level of sexual excitement and may think of intercourse or other sexual activities as pleasant. They may get most of their reward from touching, holding, kissing, caressing, attention, and approval. However, women who regularly achieve high levels of sexual response without orgasmic release of tension may find the experience frustrating. Emotional irritability, restlessness, and pelvic pain or a heavy pelvic sensation may occur because of vascular engorgement.[2,4]

Women who have not yet had an orgasm usually have some combination of the following:

- Sociocultural inhibitions that interfere with normal sexual response.
- A lack of knowledge about sex and sexuality, which interferes with normal sexual development.
- A lack of opportunity to practice in a safe, secure, socially acceptable, and private atmosphere (alone or in a relationship) in a situation that offers approval and support.
- A partner who ejaculates prematurely.
- A partner who has primary or secondary difficulty in achieving an erection.

- Genital mutilation (circumcision) that removes part or all of the clitoris, scars the genital area, or constricts the opening to the vagina. Often, vaginal intercourse is painful not only because of scarring from this procedure but also because of associated infection.

Secondary Anorgasmia. Secondary anorgasmia is the loss of ability to become orgasmic. The cause may be alcoholism, depression, grief, medication, illness, estrogen deprivation associated with menopause, or an event that has violated the patient's sexual value system.

Situational Anorgasmia. Women who are orgasmic in some situations may not be in others. A woman may have an orgasm from one type of stimulation but not from another. Or a woman may achieve orgasm with one partner but not another, or have an orgasm only under certain conditions or only with a certain type or amount of foreplay. These common variations are within the range of normal sexual expression.

Encourage a woman with situational anorgasmia to explore alone and with her partner those factors that may affect whether or not she is orgasmic, such as fatigue, emotional concerns, feeling pressured to have sex when she is not interested, or her partner's sexual dysfunction.

Family planners should consider recommending the female-above position for penile-vaginal intercourse, as it may allow for greater stimulation of the clitoris by the penis or symphysis pubis or both, and it allows the woman better control of movement. Bridging is the combining of a successful method for sexual stimulation with a desired technique so that the body learns to associate orgasm with that technique. If, for example, the woman is readily orgasmic with manual stimulation but not with penile-vaginal thrusting, she is encouraged to combine those two regularly until her body has learned to associate high levels of excitement and orgasm with penile-vaginal thrusting.

Random Anorgasmia. Some women are orgasmic but not in enough instances to satisfy their sense of what is appropriate or desirable. Often such women have trouble giving up control and allowing themselves to respond fully. Therapy can be aimed at helping them give up the need to keep their sexual feelings under control at all times.

Dyspareunia

Dyspareunia (painful intercourse) often can be resolved, even when long-standing, self-perpetuating pain is a factor. Clinicians should consider dyspareunia to be primarily a physical, rather than an emotional, problem until proven otherwise. In most instances of dyspareunia, there is an original physical cause. Among many African women, dyspareunia results from the damage caused by vaginal circumcision.

When pain occurs, the woman may be distracted from feeling pleasure and excitement. Both vaginal lubrication and vaginal dilation decrease. When the vagina is dry and undilated, penile thrusting is painful. Even after the original source of pain (a healing episiotomy, for example) has disappeared, a woman may feel pain simply because she expects pain. In brief, dyspareunia can be classified by the time elapsed since the woman first felt it:

- *During the first 2 weeks* or so, dyspareunia caused by penile insertion or movement of the penis in the vagina or by deep penetration is often due to disease or injury deep within the pelvis.
- *After the first 2 weeks* or so, the original cause of dyspareunia may still exist with the woman still experiencing the resultant pain. Or it may have disappeared, but the woman has anticipatory pain associated with a dry, tight vagina.

Dyspareunia is treated by the taking following steps:

- Carefully taking a history.
- Carefully examining the pelvis to duplicate as closely as possible the discomfort and to identify a site or source of the pelvic pain.
- Clearly explaining to the patient what has happened, including identifying the sites and causes of pain.
- Removing the source of pain when possible.
- Prescribing very large amounts of water-soluble sexual or surgical lubricant during intercourse. Discourage petroleum jelly. Moisturizing skin lotion may be recommended as an

alternative lubricant, unless the patient is using a condom or other latex product. Lubricant should be liberally applied (2 tablespoons full) to both the penis and vulva or introitus. A folded bath towel under the woman's hips helps prevent spillage on bedclothes.

- Instructing the woman to take the penis in her hand and control insertion herself rather than letting the man do it.
- Encouraging the couple to add pleasant, sexually exciting experiences to their regular interactions, such as bathing together (in which the primary goal is not cleanliness), mutual caressing without intercourse, and using sexual books and pictures. Such activities tend to increase both natural lubrication and vaginal dilation, both of which decrease friction and pain.
- Recommending a change in coital position to one admitting less penetration for women who have pain on deep penetration because of pelvic injury or disease:
  — Maximum penile penetration is achieved when the woman lies on her back with her pelvis rolled up off the bed, compressing her thighs tightly against her chest with her calves over the man's shoulders. Minimal penetration occurs when the woman lies on her back with her legs extended flat on the bed and close together while her partner's legs straddle hers.
  — If no vaginal penetration is tolerable, the couple may substitute interfemoral intercourse, in which the woman lies with her legs straight and her ankles locked (crossed). A triangular space between the upper thighs and vulva permits stimulation of both vulva and penis.

Vaginismus

Vaginismus is a painful or spastic contraction of a woman's pelvic floor muscles that occurs with attempted penetration of the vagina. Young women may be unable to begin having intercourse without pain.

Primary vaginismus. Vaginismus is commonly seen in the gynecological examining room among young women who appear afraid of their first pelvic examination. Rather than being uncooperative, such young women are actually suffering from a reflex they have not yet learned to control.

Secondary vaginismus. Vaginismus is sometimes a secondary process. A woman who had severe dyspareunia from some physical cause, such as the structural changes caused by female circumcision, may develop secondary vaginismus as a reflex. Women who have been raped, sexually abused, or examined by a rough clinician also may develop secondary vaginismus.

In general, women who have vaginismus are strongly motivated to change. Many of them can learn to break their cycle of spastic contractions even with one limited pelvic exam performed with extreme gentleness (including a one-fingered vaginal exam and omission of the rectal exam). Allow the woman to be in charge of the exam; do nothing without her knowledge and permission, and explain all parts of the examination in detail in advance. As the exam progresses, reassure the woman that her pelvic findings are normal (if they are normal). A partner can be counseled to show the woman the same degree of gentleness and communication.

Some women may require vaginal dilation as part of the treatment of vaginismus. The best vaginal dilator is the woman's own finger, which she can insert with the aid of a little lubricant.

Male Sexual Dysfunctions

Rapid (Premature) Ejaculation

When ejaculation during intercourse occurs without any sense of voluntary control and within a minute or so of insertion of the penis, it may be termed rapid because the time available for sexual pleasure is quite limited for both people. Although a few men tend to ejaculate rapidly as a response to anxiety or stress, most men who ejaculate rapidly have done so consistently from their earliest experiences with a partner.

Erective Difficulty (Impotence)

Primary erective difficulty (inability to sustain an erection sufficiently for insertion) is not common and usually has to do with high levels of anxiety about sexual performance.

Secondary erective difficulty is quite common. Its cause may be psychological, but more likely it is due to organic disease or use of pharmacologic substances. In general, erective loss caused by organic disease is persistent and progressively worsens. Men with this problem may lose sexual desire. In contrast, men whose erective loss is primarily psychogenic sometimes have a history of acute onset with a specific precipitating event. Thereafter, the erective loss does not occur on all occasions or with all partners. Night-time erections usually continue.

Organic Erective Loss. Organic erective loss is usually associated with one of four types of organic disease.

Testicular failure. In rare cases, sexual dysfunction is caused by testicular failure associated with low serum testosterone.

Endocrine disease. Diabetes mellitus is commonly associated with sexual dysfunction in three different circumstances:

- Diabetic men have the same sorts of psychogenic erective loss as other men.
- Previously undiagnosed diabetics who are not in good metabolic control may experience dysfunction, but this condition is usually reversible with good metabolic control.
- Men with long-standing diabetes and diabetic neuropathy may develop erective loss or loss of sexual responsiveness over time. This loss is usually not reversible, and these men may be candidates for a penile prosthesis.

Vascular disease. Any disease that obstructs arterial blood supply to the genitalia may affect erection.

Neurologic disease. Any lesion from the spinal cord to the genital innervation may interfere with erection, ejaculation, or both. A man may have suffered cord trauma, a cord tumor, multiple sclerosis, or

diabetic neuropathy; undergone surgical procedures; or have some other cause of this injury.

Generally debilitating disease. Debilitating diseases that affect a man's sexual function include cancer, chronic malnutrition, and starvation.

Pharmacologic Erective Loss. Other than alcohol (both acute intoxication and physical damage from chronic usage) and addictive drugs, three major kinds of pharmacologic agents are commonly associated with loss of desire, erection, ejaculation, or orgasm in men (and women):

- Antihypertensive therapy (including diuretics)
- Antidepressants and antipsychotic agents
- Anti-ulcer therapeutic agents (except simple antacids)

Any pharmacologic agent that affects the autonomic nervous system or has a potentially sedative effect may cause a change in sexual function. Because the change in function is often dose related, changing the type of medication or dose may relieve the loss in sexual function. Remember that alcohol or drug use is a common cause of both sexual dysfunction and problems with relationships.

Psychogenic Erective Loss. By the age of 40, many men have experienced one or more occasions in which they wished to have an erection but were not able to get one. A man tends to react to this experience in one of two ways. He feels some sadness and regret but does not worry unduly, or he views the situation with alarm and anxiety and suggests to himself that something in the apparatus is broken and, perhaps, it will never work properly again. On subsequent occasions, the man with the first reaction has little thought of the previous incapacity, whereas the man with the second reaction evaluates his performance repeatedly and, by so doing, rapidly distracts himself from feeling sexual excitement and pleasure.

When there is psychogenic erective loss, encourage both partners to concentrate on sight, sound, smell, touch, and taste and to fill their minds with sensation rather than allowing themselves to become distracted by thinking. Performance anxiety can also be relieved by tem-

porarily forbidding the couple to insert the penis but instead encouraging them to practice touching, caressing, and kissing and to share other sensuous and erotic experiences. Under such circumstances, erection usually returns rapidly and intercourse can occur.

Ejaculatory Delay

Delayed ejaculation almost always occurs with vaginal or anal intercourse rather than with masturbation, unless this problem is related to medication or disease. It is often caused by performance anxiety, but it also may be a learned behavior (anger at partner, unilateral contraception decision, etc.) or may occur in a man who finds masturbation more stimulating than sexual activity with his partner.

Treatment begins with having a man masturbate to orgasm with his penis close to but not inside the vagina. For example, over a few days a man masturbates until he ejaculates on his partner's vulva, then progresses to ejaculating in the vagina.

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